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OCD Awareness Week 2022

Pharmacological Treatment of OCD

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Treatments for OCD

- 1st line
  - Cognitive Behavioral Therapy (ERP)
  - Selective Serotonin Reuptake Inhibitors
- 2nd line
  - Serotonin Norepinephrine Reuptake Inhibitors
  - Clomipramine
- 3rd line
  - Augmentation
  - Neuromodulatory techniques (TMS, DBS, ECT, DCS, Etc)

Treatments for OCD

- Cognitive Behavioral Therapy
  - Best evidence is for Exposure Response Prevention (ERP) subtype of CBT
  - Can be Individual/Family oriented
  - Requires ability to tolerate ERP
  - Works well for relapse prevention/delay – longer lasting results
  - No physiological adverse effects like meds

Treatments for OCD

- Serotonin Reuptake Inhibitors
  - Best for moderate-severe OCD symptoms
  - Co-morbid disorders especially depression/anxiety/PTSD/somatic symptoms
  - Can improve symptoms sufficiently to allow for tolerance ERP
  - Adverse effects are generally tolerable
    - Nausea, GI disturbance, headache, dryness, agitation/insomnia, drowsiness, weight changes, bleeding risk, vivid dreams, sweating, sexual dysfunction, black box warning
  - Less adverse effects than Clomipramine

Optimal Treatment

- Combined treatment
  - Should always have concurrent ERP if available and tolerable due to relapse mitigation if SRI is discontinued
  - Adding SRI is useful to treat co-occurring disorders
    - Anxiety
    - Depression
    - Somatic Symptom Disorder
    - Illness Anxiety
    - PTSD

Choosing medication

- SSRIs
  - **Prozac/Fluoxetine (7+)** – agitation/insomnia
  - **Zoloft/Sertraline (6+)** – agitation/insomnia
  - **Paxil/Paroxetine (18+)** – drowsy, discontinuation syndrome risk, preg risk
  - **Luvox/Fluvoxamine (8+)** – drowsy
  - Lexapro/Escitalopram – limited doses, discontinuation
  - Celexa/Citalopram – arrythmia/QTc
- SNRI
  - Effexor/Venlafaxine – BP monitoring, drowsy,
  - Pristiq/Desvenlafaxine – BP, less sexual side effects than the rest
- **Anafranil/Clomipramine (10+)** – most GI, drowsy, weight gain, arrythmia, sexual dysfunction, dryness

Efficacy of pharmacological treatment

- SSRI vs SNRI vs Clomipramine
  - Head-to-head comparisons between have not shown any specifically to be superior for OCD
  - SNRIs have limited (venlafaxine) or no (duloxetine) studies, but similar mechanism as SSRIs predicts that they should have some efficacy
  - SSRIs have better side effect profile than Clomipramine and better support in randomized control trials than SNRIs.
- **Amelioration not elimination**
  - In general, SSRIs and clomipramine lead to improvement in 40 to 60 percent of OCD patients.
  - Average patient on adequate trial can expect a 20 to 40 percent reduction in their OCD symptoms.

Dosages of meds when treating OCD

- SSRIs
  - Fluoxetine – 40 to 80 mg/day
  - Fluvoxamine – 200 to 300 mg/day
  - Paroxetine – 40 to 60 mg/day
  - Sertraline – 50 to 200 mg/day
  - Citalopram – Up to 40 mg/day* (20 mg/day in patients older than 60)
  - Escitalopram – 20 to 40 mg/day
- Clomipramine – 100 to 250 mg/day
- Venlafaxine – 225 to 350 mg/day

Length of treatment

- American Psychiatric Association practice guidelines for people who respond to meds is to stay on for **one to two years.**
- Needs further study– relapse rates vary widely in studies, but generally lower for those who continue on meds after resolution of symptoms.
- If the medication is discontinued, American Psychiatric Association practice guidelines recommend that it should be slowly tapered
  - (eg, **10 to 25 percent every one to two months**).

What if SSRI doesn't work

- No response → switch to:
  - Different SSRI
    - About < 50% of patients will benefit from switching from one SSRI to another
    - This number diminishes as the number of failed adequate trials increase
  - Clomipramine
  - SNRI
  - Depends on individual factors
- Partial response → Augment
  - ERP – if not already onboard
  - Neuroleptic (aka antipsychotics)
    - After failed trial of at least 12 weeks of max SSRI dose
    - Antipsychotic can be effective at low doses
    - antipsychotic should be terminated after one month if the patient does not show a clear benefit. To limit exposure to risks.

Thank You!!

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